# **CHAPTER 5: Structure and Management**

Successful system reform depends on partnerships that reflect the best mix of public and private strengths. Systems that are wholly public or fully privatized have innate potential for failure, and neither type of system, in themselves, produces efficient results. Experience has shown that for the populations the State Plan targets, public entities at the state and local levels are designed to be more effective and efficient at ensuring public accountability, while community organizations are designed to be more effective and efficient at ensuring that services are provided. Those decisions that most directly affect consumers and families need to be made at the level of management closest to the consumer/family.

These findings, coupled with the realization that public funding will, at best, grow slowly, have implications for North Carolina's state and local systems. The state public system is challenged with providing leadership and oversight regarding the most efficient and effective application of current federal and state policy. This includes developing financial guidance and direction and regulatory and quality strategies that provide incentives for local systems to manage and implement public policy in a manner that best uses the available resources and achieves positive outcomes for people with disabilities and their communities.

The local public system is responsible for community-based planning, organizing and managing policy in a manner that best ensures conservation of resources while maximizing funds directed toward supports, services and treatments that produce valued outcomes and effective performance. County governments have a very important decision-making voice in reform. All of the counties contribute financially to the system and have an overarching interest in assuring that local systems respond to the needs of their citizens. Counties select the governance model for the LME, oversee the planning process and approve the local business plan that will be submitted for certification. On a regular basis, counties also review LME financial management

The local non-public provider system is charged with implementing policy in a manner that best uses public funds. This includes delivering best practice services and supports known to be effective and result in positive outcomes for people with disabilities. It also includes the ability to provide both direct (i.e., charitable contributions and alternative sources of revenue) and indirect

We support the call for analysis of the fiscal impact of the proposed changes to the system, for cost modeling, and for a pilot phase of these changes, in order to gauge the true impact of the changes on the system of care, on consumers, and on quality delivery of care." State Plan feedback augmentation of public funds through overall organizational sophistication, flexibility and a focused area of expertise that, taken together, reflects high quality performance.

Communities also have a strong role in developing and maintaining an effective local service system. The most successful systems – those with the best outcomes for people, are based on community inclusion. Community inclusion means promoting an individual's ability to acquire and maintain desired and reciprocal peer relationships like those of ordinary people, in ordinary and natural places in the community, while also providing individually needed support and accommodations that best assure access to the opportunities and experiences of full citizenship. Development of intimate relationships, friendships, acquaintances with ordinary people, economic self-sufficiency, access and use of shared natural places, assumption of citizenship roles and responsibilities and adjustments to life transitions are key evidence of community inclusion.

# ROLE AND FUNCTIONS OF THE LOCAL MANAGEMENT ENTITY (LME)

"The state and LMEs must be willing to go out of the lines." State Plan Feedback The LME is the designated leader, responsible for managing and implementing public policy within the local public system. The LME brings together every available local resource, both paid and volunteer, into an integrated, user-friendly service system that meets the needs of people with disabilities throughout the region and is consistent with state policy. The LME focuses on stewardship of limited resources by assuring that local systems serve people with the most severe disabilities and use best practice models that have been shown to result in

positive outcomes for people. LMEs evaluate their own performance and the performance of the local system by studying system performance indicators and outcome measures and by consistent gains made through continuous quality improvement activities. The ideal LME provides no direct services, concentrating its attention on developing and overseeing service provision throughout its entire region.

Administrative functions of the LME are:

# General administration and program support

- Leadership, policy development, and overall supervision of chain of command.
- Responsibility for local business plan and its implementation.
- LME accreditation.
- Liaison with county governance and administration.

#### **Business management and accounting**

- Monitoring and re-budgeting resources to core and target populations, savings from high cost to alternative services.
- Accounting, financial management and reporting.

- Claims processing and provider appeals.
- Services budget.
- Claims adjudication and payments (via IPRS, HIPPA compliance).
- IBNR (incurred but not reported) claims analysis; policy and procedures that govern claims adjudication.
- Personnel and training.
- Purchasing, payroll and contracts with entities other than providers in network (e.g. facility lease).

# Screening, assessment, authorization

(This may be embedded within routine access and emergency services)

- Conduct, screen and determine eligibility.
- Conduct assessment if person meets eligibility criteria; refer those who do not to other resources.
- Track referrals, results of eligibility assessments.
- Based on assessment, do treatment plan and authorize services.
- Formal service authorization as appropriate.

# **Utilization management**

(Not to be confused with case management)

- Define utilization management review decision points
- Develop written protocols
- Define information required for UM review
- Complete concurrent reviews (phone-based)
- Manage and respond to appeals related to UM decisions (see appeals and grievances)
- Care management

# Information management and reporting (via IPRS and Client Data Warehouse)

- Data warehouse and data analysis/reporting.
- Focus on performance outcomes and data-driven decision making.

#### **Resource development**

- Pursue additional local, state, federal, and private funds, apply for grants, etc.
- Develop community capacity.
- Provide in-service training for staff.

# Monitoring and evaluation - continuous quality improvement program

(Also known as quality assurance, quality management, and program evaluation)

- Establish consumer and provider satisfaction measures.
- Analyze data for problem identification.
- Establish protocols for risk management and safety.
- Maintain quality standards in treatment and documentation.
- Demonstrate best practices for service planning supported through case management, provider incentives and technical assistance from LME.
- Develop clinical pathways.
- Train in best practice models.
- Establish individual-level and program-level outcomes and other tools to measure results.
- Give oversight of provider client outcome system.
- Carry out needs assessment.
- Review overall quality indicators of system performance.
- Review utilization trends among target populations.
- Review waiting lists and documentation of unmet needs.

- Determine clinically appropriate and cost effective alternatives to high cost services.
- Evaluate consumer and stakeholder feedback regarding system performance and need.
- Manage continuous qaulity improvement (CQI) system for network providers to include training, data and feedback on performance, peer review, etc.
- Review and analyze incident reports.
- Carry out on site monitoring/inspections and follow up to case manager concerns or consumer/ family/community complaints.
- Investigate and respond to incidents, grievances and complaints.
- Conduct and process consumer satisfaction studies.
- Collect performance data, develop report cards for network providers.
- Conduct consumer outcome measures and analyze data for CQI.

# Provider relations and support

(With support from financial unit)

- Analyze network capacity (determine need, qualifications, locations and numbers of providers needed).
- Develop provider network (contracting with all providers qualified by Department's criteria).
- Develop contracts and negotiate rates.
- Define expectations, incentives, and consequences for poor performance and desired outcomes.
- Manage provider appeals (related to contracts and payments).
- Manage provider accreditation and staff credentialing.
- Oversee and monitor provider services (provider profiling).
- Provide technical assistance to providers on models of best practice.
- Provide *one-stop shopping* for providers (licensure, advocacy with other state agencies, etc.).

#### Consumer affairs and services

- Assist consumer empowerment and advocacy.
- Manage complaints, appeals and grievances.
- Assist consumer advisory board.
- Provide consumer education for rights, advocacy, grievances and appeals.
- Assist recovery, self- determination, self-help and empowerment support systems.

# **Community core services**

#### Community coordination

- Monitor individual case coordination done by case management.
- Provide collaboration and planning opportunities.
- Coordinate of system of care among agencies.
- Conduct formal interagency meetings as required by the state.
- Provide community education/prevention activities.
- Provide consultation.

#### Information and referral

- Answer phone calls and provide referrals as appropriate.
- Maintain database of callers' concerns and inquires.

# **Emergency Services**

These range from 24/7 on-call back-up support of local emergency system to walk-in centers and/ or mobile crisis teams.

# **Case Management**

(A service function).

Models of direct case management including client specific support coordination and service brokerage. This is not system service coordination.

# SYSTEM TRANSITION ISSUES

The state reform effort requires each area program and county to move forward to develop an LME in a single or multiple county authority or county program. This effort allows local public systems an opportunity to determine the pace, within a three-year time window, to proceed with their certification as an LME. These developmental efforts are reflected in the local business plan (LBP).

Local business plans developed by each LME will provide the basis for transition to the new system. These plans will state clearly the transition steps and timeframes that will lead their specific geographic areas to full implementation. It is understood that reforming the entire system must take place over a period of several years. Services to consumers and their families must not be disrupted by missteps in the implementation process. The first important responsibility of the LME will be to manage the local change process effectively.

Specifications for developing local business plans are contained in elsewhere in this State Plan. Local business plan design intentionally provides for designation of ongoing planning and implementation strategies to facilitate a smooth and thoughtful transition process. In addition, it is anticipated that each local area will produce a plan that prioritizes development of the various components to best meet the unique strengths and needs of the communities it will serve. All local business plans will include the following:

- A mission and values statement conforming to the State Plan.
- Focus on consumer/family and citizen involvement in all components.
- Emphasis on practice platforms and models of best practice consistent with the State Plan.
- A three-year strategic plan that includes performance goals, objectives, strategies, specific outcomes and timelines for completion.
- A plan for development of a qualified provider network.
- A methodology for providing and overseeing core functions and management of the system of services/supports to target populations.
- Financial accountability mechanisms in compliance with the intent of the reform statute and the State Plan.
- Evidence of technological capacity to meet state standards for data collection, reporting and other management information system requirements.

- A detailed quality management plan that ensures compliance with the statewide system components.
- User-friendly and consistent access processes and procedures in accordance with state uniform portal specifications.

The process for submitting and approving local business plans is contained in the local business plan section of this State Plan. There are provisions for submitting information at various stages of the process in order to provide the flexibility necessary to ensure an orderly statewide transition to the new system. The state strategic business plan, described in a technical document of the State Plan requires activities at the Division level for assisting in local planning efforts and negotiating individual issues to meet unique community needs through the transition process.

A significant number of area/county programs have indicated interest in participating in the first phase of State Plan implementation. Many of these prospective LMEs have already initiated their planning processes, and they are pursuing creative and innovative ideas. In an effort to facilitate transition and to share what is learned - both successes and challenges - the Division has asked these first programs to come together as a group to lead the transition. State staff and staff of the NC Council of Community Programs and the NC Association of County Commissioners will participate in this transition endeavor and will share information learned with all of the stakeholders in system reform. It is anticipated that the work of this phase-in-group (PIG) will inform future revisions of the State Plan, local business plan specifications and the state business plan as we move forward.

#### **Individual transitions**

There are a number of individuals being served by the current system who do not meet eligibility criteria for a target population. These people will be assisted to move to other alternatives within the system over a clinically appropriate but reasonable length of time. There are many community groups and organizations across the state that have long histories of helping people who need human services and supports. The LME will promote and encourage membership of these organizations in the local provider network. These agencies who give so much to their communities will be important and respected partners in the statewide effort to provide services to the people who need them. Members of target populations who are already receiving services but whose care, services and/or supports substantially exceed those indicated for their level of disability, must be reevaluated and the level of supports realigned in order to free up resources for others who are equally or more in need of services.

#### Community resources for non-target populations

Through a needs assessment process, LMEs identify generic community resources and other resources needed in the community. Generic community resources may include medical services, nutrition services, transportation, local employee assistance programs, self-advocacy groups such

as VOICES for Addiction Recovery, NC Mental Health Consumers' Organization, the North Carolina National Alliance for the Mentally III (NAMI-NC), substance abuse support groups and consumer groups, etc.

#### **Provider network transitions**

Area planners in nearly every region may find that the number and type of private providers currently available are insufficient to meet identified needs. Local business plans will include an assessment of the current available resources and a transition plan for developing a qualified provider network that delivers the full range of services needed in the amounts required. The local business plans will include specific strategies for building a qualified provider network and ancillary efforts necessary to minimize the impact of gaps in the network.

# **QUALIFIED SERVICE PROVIDER NETWORKS**

#### **Consumer choice**

Making sure that consumers have choices of services/supports and service providers is one of the driving forces behind the reform movement. People with disabilities need to be able to *select* their providers, services and supports, and also to *select* different ones if they find that their original choices are not satisfactory.

"The system needs to be more sensitive to what the consumers and families want. The families need more say." State Plan Feedback

Choice can be looked at along two dimensions. First is the number of active providers in the network. Adequate networks will include a range of providers in each service or specialty so that people may choose from among them. In rural areas where there are very few providers, LMEs must work actively to build their network over time. The network will be considered *adequate* only when opportunities for consumers and families to exercise informed choice are fully present. The option to choose is especially important when the provider works very closely with individuals on a frequent and ongoing basis. Case management and personal care services are examples. LMEs, whether they provide or contract for such services, must assure that individuals may select different people and providers if they so choose.

The second dimension of choice relates to the richness of the service and support array in the regional system. Emphasis here is on a continuum of options that corresponds to the levels of service people want and need. For example, it is preferable to have a single agency that develops three levels of supported housing/residential programs than to have three agencies that provide one single level. A person with a disability should not be forced to choose a group home when he/ she is capable of living more independently. Neither should anyone be forced to opt for day activities that are static or not stimulating simply because nothing else has been developed. To provide a more robust service/support array LMEs may need to look at sharing resources and going across area/regional boundaries to enhance the availability of options. In addition, the local system must

evolve in a manner in which people with disabilities, allied with others who care about them, may not only choose from among available services, but will have the opportunity to compose their own supports and services as well. The system must sustain a viable mix of services and supports. Again, developing a full array may need to take place gradually but it must be an integral part of all regional planning.

# **Network development**

This section responds to requests for additional clarification and information on provider network development. Questions have focused mainly on issues relating to the selection and numbers of providers to be admitted, that of LMEs acting as both regional manager and direct provider of services and guidance for LMEs divesting themselves of direct service provision.

# Network membership

Department **s**ecretary Carmen Hooker-Odom has stated publicly that providers who wish to receive public dollars – Medicaid or state – *must* join the local provider network. While this policy provides a helpful incentive for providers to participate in the new system, it also places an obligation on the LME to admit qualified providers who wish to join. Providers who are already receiving public reimbursements or those who elect to participate at a later date may not be excluded as a way of limiting network size. This applies primarily to single or group practitioners who are reimbursed on a fee-for-service basis and does not establish an obligation to provide a pre-arranged number of referrals.

Services or programs such as habilitation or rehabilitation programs, supported employment services, emergency/crisis systems, agencies that provide ACT programs, and similar service/program categories, lend themselves best to contracted arrangements. When determining the necessity and quantity of the service/program, the LME should ensure that:

- Models of acceptable practice are defined.
- Scope and economies of scale are considered.
- Cost parameters per service category have been determined.

Once these factors have been agreed upon, recruitment and selection may be handled by issuing requests for proposals and awarding contracts to the best applicants. The selection process must include participation and recommendations of people with disabilities and their families. All such contracts shall be re-bid at least every three years.

#### LMEs as direct providers

The ideal LME provides no direct services. Rather, the LME devotes its attention to managing and coordinating the array of services and supports across the entire region. However, every region has unique characteristics - greater or lesser numbers of potential network members, the presence or absence of specialty service providers or any number of other factors that impact local transition to the reformed system. Therefore, decisions about the LME providing direct services have to be

made on a case-by-case basis, considering the specific circumstances. Factors to be weighed include:

- Efforts expended by the LME to attract and retain an adequate private provider network.
- Possible divestiture of current area program clinicians to a private, non-profit arrangement.
- Level of community support for the LME to continue providing some services pending development of an adequate network.

# Service delivery divestiture options

Some area programs (APs) have initiated efforts to *spin out* (movement of AP direct service staff to existing provider organizations) and/or *spin off* (movement of AP direct service staff to newly developed provider organizations) as part of an overall strategy of developing a sound and comprehensive competitive provider network. The rationale behind the these efforts is:

- To ensure that transition efforts are not disruptive and/or create a break in services for people with disabilities who are currently being served. This includes preventing a full-scale comprehensive shift in staff delivering services at a single point in time.
- As a mechanism to provide opportunities for staff to remain employed in the field, including increasing their certainty of future employment. This is particularly intended to minimize an increase in staff turnover and the corresponding problems in service delivery during the state reform transition timeframe.

These practices are acceptable. However, they must adhere to the following conditions:

- They shall neither inhibit nor relieve the AP (prospective LME) of their responsibility to aggressively and continuously recruit and retain a competitive and comprehensive provider network.
- This effort shall be only a part of the overall strategy to build the provider network.
- The AP (prospective LME) shall have no tie to these organizations that is unlike the ordinary relationship it would have with any other provider organization. For example, the AP (emerging LME) director may not be on the organization's board of directors.
- These organizations shall be legally freestanding organizations.
- The transfer process shall not place these organizations at an unfair advantage over any other provider organizations.
- Every and all components of the transfer and transition shall not create an immediate or future unfair advantage over other provider organizations.

- The organizations shall be expected to compete in an equal and fair manner with all other comparable entities, in terms of services provided, provider organizations that are in the network at the point of transfer and into the future.
- As shall be expected of all provider organizations, these organizations shall be required to shift practice expectations to the expectations of the state agency purchasing services through the LMEs. If service practice expectations as well as quality, effectiveness and efficiency expectations are not met (outcomes, systems performance and regulatory compliance), these organizations shall be treated equally and suffer the same consequences as any other provider organization.

Emerging LMEs who divest any or all of the services they currently directly deliver through recruiting suitable provider organizations, must develop transition plans for the orderly transfer of service components. These plans are to assure that there is no disruptive break in service and that the people being served are fully informed and supported in their transition to the new arrangement.

# Qualified service provider network/direct enrollment

Widespread comment has been received requesting both expansion of direct provider enrollment and ending direct enrollment. Currently, directly enrolled providers submit billings and receive reimbursements for Medicaid covered services directly through the Division of Medical Assistance (DMA/Electronic Data Systems (EDS) rather than via area program claims management processes. The advantage to the provider is faster reimbursement for services by eliminating the middle step—the area program. The advantage to the area program is that directly enrolled providers bill using their own Medicaid provider number rather than that of the area program, thus, reducing the area program's liability for payback if inaccurate billings are submitted by providers.

With the rollout of the IPRS system underway, direct enrollment can now include reimbursement for state funded services as well. The State Plan implementation committee on quality of care established a workgroup to study the issue of direct enrollment and provide recommendations. The group's report is currently under review. Whether or not direct enrollment is eventually expanded, all providers in the network will be subject to the same LME referral mechanisms and utilization management criteria and procedures regardless of the payment source.

Direct enrollment requirements in the future will be linked with licensure and performance of quality indicators. The ability to meet outcomes will be used to measure performance and eventually will be linked to payment of services. This shift has many implications and will be one of the final steps of implementation. As an interim step, reports of qualified provider performance will be published and will be an integral part of educating individuals and families about selection of qualified providers. These reports will also be used as a factor in examination of qualified provider rates.

Memoranda of agreement (MOA) will be required of all members of the LME's qualified provider network. This will include all directly enrolled qualified providers who make services available to target populations, including ICF/MR group homes, adult care homes and state operated services. A standardized MOA is currently under development and nearing completion.

# DEPARTMENT COORDINATION AND INFRASTRUCTURE

# **Division leadership**

The Division of Mental Health, Developmental Disabilities and Substances Abuse Services has new leadership. Richard Visingardi, Ph.D. began his tenure as the Division's director on February 4<sup>th</sup>, 2002. A Division reorganization plan has been designed to more closely support and facilitate implementation of the State Plan and the reformed system. The reorganization plan includes advocacy and customer services.

This State Plan requires changes in Division practices, leadership methods and business functions. Division staff will need to develop new/different sets of skills to meet the challenges of system reform and to be effective leaders in the new system. Just as providers in the regional networks will expect the LME to effectively manage regional issues and be responsive to problem areas, LMEs must be able to look to the Division for leadership and technical assistance in developing the new regional systems. They will also expect dissemination of clear and concise Division policies consistently applied throughout the system. An overview of the Division reorganization is included as a technical document in this State Plan revision.

### **Intra-Departmental coordination**

Department divisions are working together to develop and revise programmatic policy and to address administrative and business functions. Particular attention is being paid to areas in which multiple divisions and departments work on similar issues, such as health, employment, housing and transportation. The Division of MH/DD/SAS, Division of Medical Assistance, Division of Facility Services and Public Health are organizationally located under the Assistant Secretary for Health and, as such, are working on several joint initiatives. These divisions are specifically looking to enhance coordination in the areas of financing strategies, case management protocols and best practice models to make maximum use of funding opportunities. Although much work remains to be accomplished, progress is being made to promote coordination.

Another major area of cross-Departmental coordination rests in the long-term care cabinet, appointed by the Department secretary in 2001. All divisions with interest in long-term care are together exploring policy unification of issues ranging from provider qualifications to self-determination. The Office of Long-Term Care, which staffs the cabinet, manages the Real Choice Systems Change Grant received from CMS to improve the quality and stability of the direct care work force. The Department has received two additional Systems Change Grants, one focused on consumer-

directed supports (Community PASS) and the other to promote nursing home transition. The Division manages the Community PASS project, but all of the grant work is being coordinated through the Office of Long-Term Care. Another component of this effort is development of a coordinated strategy for integrating the Olmstead, long-term care and state mh/dd/sas plans.

In addition to coordination across Department divisions, the Division of MH/DD/SAS must work across departments on several fronts. *State Plan 2001, Blue Print for Change* called for a study to effect improvements in advocacy and ombudsmen operations. This effort has included the Governor's Advocacy Council for People with Disabilities within the Department of Administration as well as several other Department divisions. There are many other cross-Departmental initiatives necessary for implementation of the State Plan, including work with the Department of Corrections, Department of Juvenile Justice and Delinquency Prevention, Department of Transportation, university and community college systems, and the federal Housing Finance Agency. The state strategic business plan addresses specific collaboration tasks and strategies, many of which are already underway.

#### **DOCUMENTATION**

Reporting requirements currently in use are under review to determine whether they have continuing legitimate value for the new system. Necessary documentation requirements include service records, federal reporting requirements, financial management activities including information needed to process and settle service claims, statistical data intended to measure system outcomes and performance and others.

A task force within the Division has been revising the service records manual for area programs and contract agencies (APSM 45-2) since autumn, 2001. The group has completed the revision and forwarded its recommendations to Division management. The manual will go into effect upon final approval. Qualified providers/agencies are accountable to the people they serve, to their communities and to their funding source. Such providers assume liability for the quality of their records. Local managing entities will be responsible for ensuring that qualified providers receive accurate and timely information. The Division and/or Department will distribute materials to directly enrolled qualified providers.

Documentation is also essential for billing services to third parties (insurance companies, government agencies, etc). Third parties may arrange for periodic audits to ensure that they are getting what they pay for. Records and charts will be examined during audits along with other relevant information and data. Public and private agencies will be audited using the same standards and criteria except as mandated by federal or state law and rules. Results of Division audits, monitoring visits or investigations will be published within 45 days of review and will be used for quality management activities and reports cards.

The Division, however, is mindful of the widespread concern about the burdens of excessive documentation and reporting. While reporting requirements change over time as service and management processes change, the system needs to make documentation requirements as flexible and simple as possible and discontinue what is no longer necessary. The Division will promote the use of technology to expedite documentation and reporting procedures and will look for ways to consolidate functions throughout the Division and Department to minimize paperwork at the local level. As we evolve to an outcome-based system, quality assurance activities will significantly decrease their reliance on paper reviews.

# LICENSURE AND MONITORING SERVICES

The Division monitoring workgroup has completed a draft of a working model for system monitoring under the State Plan. This report is under review. Assumptions and priorities used by the monitoring workgroup were explicitly derived from the State Plan and additional considerations established by the workgroup. The monitoring component of the State Plan has an identified deliverable date of October 1, 2002.

These components included:

- Stewardship of state resources.
- Statewide consistency through statewide oversight and inter-rater reliability.
- No duplication.
- Family/consumer involvement.
- Outcome-oriented.
- Participant-driven and person-centered.
- Data collection priority.
- State-established monitoring criteria.
- Licensure of all services.
- Routine monitoring centers at LME, using a QI/corrective action approach.
- State monitoring of items identified as trigger issues.
- Accountability to all federal and state rules and laws

The Division of Facility Services (DFS) is the regulatory agent for state oversight of licensed services. DFS will be responsible for conducting inspections for compliance with licensure requirements. Results of these inspections will be published and used as quality indicators for performance.

The LME will monitor qualified providers within the network. Local monitoring will focus on the quality of clinical and programmatic delivery and will not be considered a licensure inspection. The monitoring workgroup is developing standardized monitoring protocols and criteria.

Licensure for professional practitioners will be used as an indicator of qualification for service. Direct enrollment will be evaluated for all licensed practitioners. In the future, qualified providers of non-facility based services will be subject to licensure or compliance with identified standards.

# STATE AND LOCAL CONSUMER AND FAMILY ADVISORY COMMITTEES

Each prospective LME will establish a consumer and family advisory committee (CFAC). The CFAC will convene at the beginning of local planning efforts and will have an active role with delineated responsibilities throughout the planning process. The group will advise staff regarding the local planning effort and will review and submit a separate report(s) on local business plans to the Division.

The CFACs will have clearly specified relationships to county/area boards as described in local business plans. Each local advisory committee will be staffed by an employee of the LME whose responsibilities will include:

- Obtaining consumer and family input from the community.
- Carrying forward recommendations of the advisory committee for implementation.
- Serving as liaison to the state advisory committee and other local agencies, organizations and associations.
- Recruitment of initial members of the local advisory committee in collaboration with local consumer and family advocacy organizations.

The Division will convene a CFAC that is composed of representatives of the local committees. The composition of both the state and local CFACs will reflect:

- 100 percent consumers and family membership.
- Equal representation of all disability groups.
- Membership representative of the race and ethnicity of the community.
- Representation for each disability group including a man, a woman and a youth member. (Family members may represent children. A parent may represent the needs of parents of adult consumers, but may not represent adult consumers.)

Roles and responsibilities of the state and local advisory committees will be established according to specifications outlined in the state strategic and local business plans. They must be consistent with the principles of the State Plan and address the following:

- Advise and comment on all state and local plans.
- Recommendations on areas of service eligibility and service array, including identifying gaps in services.
- Assist in the identification of under-served populations.
- Provide advice and consultation regarding development of additional services and new models of service.

- Participate in monitoring service development and delivery.
- Review and comment on the state and local service budgets.
- Observe and report on the implementation of state and local business plans.
- Participate in all quality improvement activities, including tracking and reporting on outcome measures and performance indicators.
- Ensuring consumer and family participation in all quality improvement projects at both the provider and LME levels.

The state strategic and local business plans, technical documents of the State Plan, provide for the creation of a support system at both state and local levels to ensure consumer/family participation and viability of the CFACs. The support system will include consideration of the following:

- Stipends as appropriate to ensure participation.
- Transportation or compensation for travel expenses.
- Childcare and eldercare if needed.
- Flexible scheduling of meeting times.
- Information and education regarding the service system, including funding sources, the system for access and service availability.
- Materials regarding system reform practice platforms and models of best practice.

# APPEALS, GRIEVANCES, HUMAN RIGHTS, CONSUMER ADVO-CACY

The reform statutes require a wide range of activities to ensure fairness, consumer choice, consumer rights and protections, individual and system advocacy efforts and effective quality management. There are also a number of existing avenues to address appeals, client/human rights and advocacy. An implementation workgroup of consumers was convened to study the possible benefits of consolidating these activities. This study has, for the first time, identified all of the advocacy and ombudsman efforts throughout the Department and found that they are more numerous than first anticipated with a scope that has grown proportionately. The workgroup prepared an interim report for the Division director and the Department secretary this spring. A second progress report with limited recommendations has recently been submitted and is under review. Final plans must be approved by the Department secretary and will be presented to the LOC.

# **TRAINING**

Training and technical assistance are fundamental to the reform effort and will become an integral component of all Division work. Education and training efforts at the state level will be coordinated within the Division and across the Department. The state strategic business plan outlines a significant collaboration effort to include all training venues in the state to expedite reform. Local business plan specifications include a variety of training activities that will be the responsibility of the

LMEs. State and local training, information, education and technical assistance will be directed to the many stakeholder audiences and will address all aspects of system reform. All of these activities will be conducted consistent with the principles in the State Plan and will:

- Reflect the latest research, best practices and state-adopted practices.
- Positively affect consumers and their families.
- Be self-sustaining to the extent that individual training efforts are part of larger plans and continue on a regular basis.
- Be accessible throughout the state or region as appropriate.
- Increase local capacity to provide services and supports.
- Result in permanent workplace change.
- Be sensitive to all cultures.

#### **INFRASTRUCTURE**

# Collection and analysis of data

A variety of data will be collected and analyzed for purposes of planning, establishing benchmarks, measuring individual and system outcomes and informing decision-making. All area/county programs and other qualified providers shall participate fully in the state's efforts to study and evaluate system components. However, the state must also be mindful of the need to eliminate unnecessary reporting requirements and avoid excessive documentation rules for providers.

# **Integrated payment and reporting system (IPRS)**

Three reporting and payment systems now used are being replaced by the Integrated Payment and Reporting System (IPRS). Also underway is a project to implement a decision support information system. IPRS uses internet and mainframe technology and is part of a major effort to upgrade the Division's management and information system. The IPRS will be used by the Division to process, track, pay and report on all claims submitted by providers for services rendered to its constituent population. Its implementation will solve problems in current unit cost reimbursement systems by allowing LMEs to submit a single claim to the state and receive payments from the proper funding source, including Medicaid, MRMI Services, At Risk Children's Program, Pioneer and capitated risk contracts. It also provides many significant new capabilities in the areas of utilization management and tracking and reporting services to consumers. The system provides the Division and IPRS endusers with the following advantages:

- Provides an opportunity to modernize important business functions
- Provides a sound basis for purchase of services
- Establishes central consumer and provider databases
- Reduces duplicate billings and payments
- Ensures Medicaid is the first payer

# IPRS implementation timeframe

Two area programs, Duplin-Sampson-Lenoir Area Program and Southeastern Center, have served as pilot sites for the new system, which is scheduled to begin statewide rollout on July 1st, 2002. The first step in using IPRS is determining the individual's eligibility for public services; that is whether the person is a member of a target population. Since the target populations have been adjusted based on widespread feedback, work to incorporate the changes may delay the rollout by a few weeks. Implementation is expected to occur in four phases according to the following schedule. This schedule is subject to change, however, depending on LME configurations and mergers selected by the counties:

**Phase 1** Guilford Center for Behavioral Health and Disability Services; New River Behavioral HealthCare; Pathways MH/DD/SA; Smoky Mountain Center for Mental Health, Developmental Disabilities and Substance Abuse Services; Vance Granville Franklin Warren Area Authority; Wayne County Mental Health Center

**Phase 2** Lee-Harnett Area Mental Health, Developmental Disabilities and Substance Abuse Authority; Mecklenburg County Health, Mental Health and Community Services; Orange-Person-Chatham Mental Health, Developmental Disabilities and Substance Abuse Authority; Sandhills Center for Mental Health, Developmental Disabilities and Substance Abuse Services; Southeastern Regional Mental Health, Developmental Disabilities and Substance Abuse Services; The Durham Center Tideland Mental Health Center; Wake County Human Services; Wilson-Green Area Mental Health, Mental Retardation and Substance Abuse Services

Phase 3 Alamance-Caswell Area Mental Health, Developmental Disabilities & Substance Abuse Authority; Albemarle Mental Health Center & Developmental Disabilities & Substance Abuse Services; Blue Ridge Center for Mental Health, Developmental Disabilities & Substance Abuse Services; Crossroads Behavioral Healthcare; Cumberland County Mental Health Center; Davidson County Area Program for Mental Health Developmental Disabilities & Substance Abuse Services; Johnston County Area Mental Health, Mental Retardation & Substance Abuse Authority; Mental Health Services of Catawba County; Centerpoint Human Services; Onslow County Behavioral Healthcare Services; Neuse Center for Mental Health Developmental Disabilities & Substance Abuse Services; Piedmont Area Mental Health, Mental Retardation, & Substance Abuse Program; Roanoke-Chowan Human Services Center

**Phase 4** Edgecombe-Nash Mental Health, Developmental Disabilities & Substance Abuse Services; Foothills Area Mental Health, Developmental Disabilities & Substance Abuse Program; Pitt County Mental Health Developmental Disabilities & Substance Abuse Center; Riverstone Counseling & Personal Development; Rockingham County Area Mental Health Developmental Disabilities & Substance Abuse Program; Rutherford-Polk Area Mental Health, Developmental Disabilities &

Substance Abuse Authority; Trend Area Mental Health Developmental Disabilities & Substance Abuse Authority

# System quality management plan

Quantity or adequate provision of a particular service or compliance with a specific regulation is *not* a measurement of outcome. These measures may indeed provide necessary information to manage systems; however, the ultimate measurement of outcomes is related to real life changes for people with disabilities and the system's performance relative to those outcomes.

Outcomes fall into four broad categories:

- 1. Changes in the quality of an individual's life. These include measurements throughout all life domains cultural, educational, vocational, financial, living arrangements, spiritual, relationships, recreational, as examples.
- 2. A person's satisfaction with his/her life as well as the supports and services he/she is receiving, including an evaluation of the proper application of person-centered planning.
- 3. Negative life events such as episodes of residential instability and homelessness or incarcerations in jail.
- 4. The costs associated with achieving real life outcomes including factors such as level of satisfaction and the possible occurrence of negative events.

The aggregate measurement of outcomes, taken along with regulatory compliance and application of best practice and emerging best practice in administrative, management and programmatic roles, provides a composite of overall systems performance.

System-wide quality management and continuous quality improvement focused on achieving positive outcomes for the people served provides vital information both to state and local systems and to system stakeholders - people served, families, advocates, legislators and taxpayers - about system performance in a practical, realistic way. Measuring outcomes also allows the system to compare itself with other, similar states that are tracking many of the same outcomes. Finally, tying quality and continuous improvement efforts to real life outcomes for people gives new meaning and importance to uncovering system weaknesses that provide opportunities for improvement.

The quality management system must also strive to continuously move the system toward emerging best practice. It is this component of the mh/dd/sa system that will remain aware of ongoing

research, new medications, improvements in treatment techniques and evaluative processes for determining the effectiveness of the system. Research has given us a better understanding of the disease of addiction and has led to improvements in treatment techniques. Recent research has focused on development of medication that reduces craving for opiate and cocaine addicts, as well as comparisons of psychotherapy techniques to determine which treatments or preventive interventions are most effective for which consumer groups. The development of new medications in recent years has also significantly improved the outcomes for many persons with severe and persistent mental illness. Medical research and development of assistive technology have greatly improved quality of life for many individuals with significant physical and cognitive disabilities. All of the State Plan's target populations have witnessed the positive effects of applying emerging best practice with ongoing evaluation.

The public service system must find ways to bridge the gap between research and practice. Examples of North Carolina's efforts include the National Institute on Alcohol Abuse and Alcoholism (NIAAA) *Researchers in Residence* Program, the National Institute on Drug Abuse (NIDA) Clinical Trials Network Initiative, and the Center for Substance Abuse Treatment (CSAT) Practice Improvement Collaborative. The Division supports research as a collaborative effort between our state facilities and the university system. The result of much of that research is published nationally and put into practice throughout our state. The state strategic business plan includes tasks and strategies to increase our awareness and application of emerging best practices.

# Report cards

The new system needs to be one in which success is acknowledged and celebrated and shortcomings are identified and dealt with. Periodic report cards on system performance in achieving positive outcome goals will be published on a regular basis. The first of such report cards will be published in July 2004.

"LOVE the report cards!" State Plan feedback

# STAFF COMPETENCIES, EDUCATION AND TRAININGC

Competency-based system for qualified service providers is in development. Its purpose is to raise the level of quality and consistency statewide for delivery of services to people with disabilities and to achieve measurable outcomes. This effort is consistent with the national move toward competency-based requirements for billable services. Recognition is also given to those licensing and certification boards already in place and serving people with disabilities well.

The current design includes seven core skill areas required to meet minimal standards for a competency-based system for staff services in North Carolina:

- 1. Technical knowledge. 4. Decision-making. 7. Clinical skills.
- 2. Cultural awareness. 5. Interpersonal skills.
- 3. Analytical skills. 6. Communication skills.

Several implementation phases are necessary to build a solid, cost effective, stable system that will achieve measurable objectives. The rewards of a competency-based qualified provider system can be:

- Better personal outcomes for people with disabilities through more stable support systems.
- Less staff turnover and reduction of associated costs with replacing and training new personnel.
- Reduction in administrative costs through standardizing qualifications and competencies for professionals and paraprofessionals.
- Improved professional ethics and standards.
- Higher morale and more motivated employees.
- Streamlined, cost effective statewide standardization of qualification and documentation processes for professionals and paraprofessionals.
- Improved quality outcome indicators that can be measured against national standards (accident injury rate, staff turnover, etc.).

Determining staff competencies and applying them consistently across the state and among all disability groups is a difficult task. This task is complicated further by movement of the system to one that is consumer-driven and provides more flexible options. Prior to implementing the system statewide, the Division will assess the cost benefits of such a system as well as any measurable impact on quality.

# Rules adoption and statute revisions

The *State Plan 2001: Blue Print for Change* included a report on rules and statutes in need of review to determine if the existing regulatory framework supports the reform effort. An implementation workgroup on rules coordination has developed a streamlined process to ensure that existing rules undergo review and amendment, if necessary, and that proposed rules are reviewed for consistency with the reform effort and among divisions and Department. This work will include clarifying processes for establishing Division policy, regulation, standards, rules and statutes and differentiating among these provisions. Consumers and families, through their membership on implementation committees and workgroups, provide recommendations on the need and substance of regulatory reform.

This spring, the sub-committee of the Legislative Oversight Committee (LOC) focusing on the Commission for Mental Health, Developmental Disabilities and Substance Abuse, raised concerns about multiple rulemaking bodies and processes throughout the Department. As a result, the LOC put forth draft legislation requiring the Department to establish a rulemaking process that eliminates duplication and overlap and that identifies rules that are in conflict or are redundant among the various rulemaking bodies within the Department. The Department will take this opportunity to continue its review of rules for vagueness, duplication and ambiguity. In addition to reviewing existing rules, the Department will issue new rules, policies, standards and/or regulations to promote reform and a coordinated system of care. The Division of Medical Assistance (DMA) and the Division of MH/DD/SAS will cooperatively plan any policy or rule making in order to meet the

mission of a unified system and to meet statutory requirements of both agencies for rules and policies.

This plan requires realignment of nearly all of the regulatory components within the system in order to implement reform and provide an array of services/supports/treatments consistent with best practice platforms for targeted populations. The Division has initiated review and will pursue amendments or modifications to the following, as necessary:

- Service definitions and standards.
- Management information system requirements.
- Licensure rules, regulations and practices.
- Documentation requirements.
- Clinical care guidelines and protocols.
- Medical necessity criteria.
- Monitoring requirements and performance criteria.
- Readiness requirements and review procedures for LMEs certification.
- Competency requirements for staff.
- Fiscal rules, policies and procedures, including audit guidelines and rate setting.

# FINANCE STRATEGY

Like many other states, North Carolina is experiencing an economic downturn and is struggling with a financial crisis unmatched in recent history. Balancing the state's budget will require far more than a temporary belt-tightening. Forecasts for next year offer little hope of a quick recovery. This is a particular challenge facing the state reform and plan efforts.

The current finance strategy revolves around a single practice – billing. A fee-for-service strategy is just that – provide a service and receive a fee. Best practice finance strategies are evolving around the nation. These strategies all link management of funds with expectations identified in this plan, including linking state facility usage to community funding and best practices. Although North Carolina's specific strategy is not fully complete, it seems highly unlikely that the future will be financed only through a fee-for-service system.

The budget crisis must affect the manner in which finance strategy is developed. The overall strategy must be developed with the more immediate budget crisis and related tactical concerns in mind. At the same time, these tactical considerations require two characteristics: first, the need to reflect the opportunities inherent in a budget crisis; and second, the need to be consistent with elements of the strategy that will roll out over the next several years.

The role of the LME is key in the management of public funding. It is related to the ultimate finance strategy intent of: (a) expectations of exemplary LME systems performance, (b) clearly

identifying and justifying indirect costs of public local management, and (c) increasing availability of funds for direct supports, services, treatment and care. Reductions in prescriptive practices will result in reduced indirect spending and burdens on direct service provision with an ultimate real and residual increase in the direct provision of services.

Achieving public policy objectives requires a corresponding finance strategy that provides the necessary incentives and disincentives that bring about behavior changes critical to meeting public policy expectations. This includes shifting reliance on expensive institutional care and the fixed costs associated with maintaining facilities that perpetuates an outdated service delivery model and drains the system's limited resources.

To this end, the state reform and Plan have three key public policy expectations as foundations of the finance plan. The system must be:

- Consumer-driven and person-centered.
- Accountable for its stewardship and performance.
- More efficiently managed.

To support these three policy expectations, a finance strategy must provide the necessary incentives and disincentives that effect behavior critical to the achievements of the mission and vision and policy. Although these policy expectations are explained more fully in early sections of the State Plan, listed below are descriptions of their impact upon the financing plan.

#### Consumer driven

**Expectation #1:** The ultimate finance strategy will be tied to expectations that the system is consumer driven.

A consumer driven system is characterized as a demand-oriented market, meaning the consumer decides what type of service/supports are needed, and the provider system meets the demands. This is different than the current system in that consumers are told what services are available, and they are *fitted* into slots or vacancies, even if it is not the best or most efficient option. A consumer driven system defines the consumer as the intended direct beneficiary and the public as the intended indirect beneficiary. The system is the residual beneficiary, meaning it is financially rewarded for providing supports, services, treatment and care in a consumer driven publicly accountable market. It should also be noted that as this involves the use of public funds, consumers are responsible purchasers. Therefore, the ultimate finance strategy will be tied to expectations that the system is consumer driven.

It is expected that an informed and responsible consumer driven approach to systems development will promote an increase in both the efficient and effective use of public funds.

# Systems performance

**Expectation #2:** The ultimate finance strategy will pay for expectations of systems performance.

Simply regulating systems and monitoring for regulatory compliance only provides a limited view of the performance. In fact, excessive and ill-defined regulations and monitoring may in themselves be inefficient. Overall performance relative to intended measures of performance and outcomes such as penetration rates, consumer-related outcomes, etc., is the comprehensive measure of systems. Therefore, the ultimate finance strategy will pay for expectations of systems performance.

It is expected that a system designed and managed in performance will find diminished management related costs such as indirect costs associated with agency administration and program management at the state and local levels and in the public and private sectors.

# Accountability

**Expectation #3:** The ultimate finance strategy will not assume a complete *free market* approach to assure efficiency.

Each of the system entities — public entities, non-profit organizations and for-profit firms — brings strengths with the roles they have been assigned in the State Plan. Systems performance, delegation of roles and competition are examples of exemplary practices associated with systems accountability in a system that is consumer-driven. However, a public mh/dd/sa system is not a true market driven system. Therefore particular policy interventions are intended to promote a more market like atmosphere. These interventions are intended to promote the public trust and ensure the most efficient use of resources as a financial incentive structure. Therefore, the ultimate finance strategy will not assume a complete *free market* approach to assure efficiency; it will, however, contain sufficient and efficient attributes to promote accountability.

It is expected that an accountable system built upon a consumer driven and systems performance focus will ultimately result in increased availability of resources to be provided for effective, efficient, quality and needed direct supports, services, treatment and care. Administrative costs must be aligned with the purposes of the overall management strategy.

The State Plan outlines seventeen specific strategies designed to move the system forward while dealing with the reality of the current budget situation. They are organized below by their content areas and by the timeframe during which they will be implemented.

# SFY 02/03: Demonstration of competency and foundation building

The budget crisis creates an opportunity for the system to demonstrate leadership and fiscal and management competencies. These competencies are also necessary in the evaluation of readiness to implement the State Plan. The focus of SFY 02-03 will involve state, local and provider systems being provided an opportunity to demonstrate competencies that will be required over time. These efforts are also intended to provide practice clarity necessary for the completion of the local business plans (LBPs). Additionally, these efforts are intended to build a fiscal foundation regarding practices, in which resources are arranged and base revenues are necessary for future financing

innovations. These efforts are intended to mitigate budget reductions. Finally, the efforts of SFY 02-03 are intended to set the course for all future financial strategy plan development. Along with the State Plan revisions offered in this document, there are several products that will be delivered by the Department in SFY 02-03 to provide direction and clarity. They are:

# 1. Coordinated realignment of funding

**Objective:** A funding strategy that supports reform with a course set in 02-03.

This component of the Plan provides initial detail of SFY 02-03 finance strategy planning and constructs the framework for the continuous evolution the strategy. Coordinated by the assistant secretary of health and in conjunction with the deputy secretary, an inter-Departmental team consisting of the Division of MH/DD/SAS, DMA, office of policy and planning, office of budget and financing and controller's office will be responsible for full conceptual-to-technical development of the finance strategy. Other Department systems such as the divisions of social services, facility services and public health and other external key informants and stakeholder systems will be consulted on an as-needed basis by this group. The principles of system reform will guide this group's work.

# 2. Re-organization

**Objective:** To array Division resources in a manner that supports local management of system resources and away from an institutional focus.

The Division reorganization, included in this Plan, will be fully implemented by January 2003 to coincide with delivery of the first components of the local business plans. Division function will reflect two critical changes:

- (a) Integration of State Plan activities into the formal organization.
- (b) A shift from an intensive, prescriptive relationship with local systems to a relationship that is based on a more supportive and oversight role related to expectations of systems performance.

The Division will model the achievement of efficiencies by adjusting its size commensurate with changes in its approach and responsibilities.

Item (b) is related to the ultimate strategic intent that the state is interested in financing systems performance as opposed to fee reimbursement for expenditure-based services and functions.

#### 3. LME cost model

**Objective:** The LME cost modeling project will be completed and produce critical information regarding best practice protocols related to LME functions, core functions and market-based cost estimates for these practices.

The intent of the LME cost model is to assure sufficient economies of scale and scope, such as population and size expectations, and to build LME budgets based on a clear delineation from provider responsibilities, such as those related to direct service program management and agency administration. In terms of financing, the Department has made it clear that LME functions must be

paid for within *existing resources*. This is obtainable, as the state will only purchase LME functions that are within the scope of the cost model.

Each LME must make efficient choices regarding whether it ought to *make* the infrastructure necessary to meet defined LME responsibilities, or whether it ought to *buy* some of this functionality either from the private market or from each other.

It will be imperative for the LMEs to employ or purchase these functions in an exemplary manner, as the state will not subsidize costs associated with inefficiency. Current administrative costs reflect the fee-for-service model, current cost-based reimbursement mechanisms and are largely unrelated to quality. There are both historical inefficiencies and some competency issues. *Existing resources* will therefore come from changing the way current area program administrative resources are utilized and by building in budget assumptions that reflect competency and efficiency (i.e., quality). In fact, with all requirements of the model met, LME functions will be more efficient in comparison to those area programs currently expend on administration.

#### 4. Market cost model

**Objective:** Rate setting methods will change to better align resources and move away from cost-finding and settlement focus toward a more market-oriented approach.

Current rate setting is based on cost-finding methods and negotiations between provider organizations (including area programs) and the state. Some of this effort equates to current expenditure-based budgeting methods in a system that can be described as a *quasi-market* at best. Similar to the LME cost modeling project, determining new ways to identify and contain costs associated with supports, services, treatment and care (including the related program management and administration costs) will be developed. These new reimbursement models need to reflect a system in which services are delivered increasingly through private entities. Costs developed in this state should be compared to costs experienced nationally, taking into account critical variables (e.g., population, urban/rural mix, cost of living, similarity of service definitions and provider qualifications). The result should reflect a more neutral and *non-interested* market range for supports, services, treatment and care. Costs and rates should be reflected in the Medicaid component of the financial strategy in a manner that optimizes the use of federal financial participation.

This effort is related to the ultimate finance strategy intent of: (a) expectations of exemplary provider systems performance; (b) clearly identifying and justifying indirect costs of provider systems and (c) increasing the availability of funds for direct supports, services, treatment and care.

# 5. Funding fairness

**Objective:** A distribution plan will be developed that will reflect: (a) consideration of all essential variables necessary to accommodate variations in communities and (b) phase-in plan to mitigate adverse effects of re-distribution.

Current allocations of state funds have been described as lacking any logical fairness in distribution. Equity and consistency are core values of system reform. A distribution plan will be developed that will reflect consideration of all variables necessary to accommodate variations in communities and will include a phase-in plan to mitigate adverse effects of re-distribution.

This effort is related to the ultimate intent of finance strategy that uses fair methods to promote resource equity across the state.

#### 6. State Medicaid Plan revisions

**Objective:** Making optimum use of community based Medicaid funded services is a linchpin in the financial strategy.

The Medicaid State Plan will be revised to better reflect support, service, treatment and care expectations of the reform efforts. Careful consideration will be given to recommendations developed and the experiences of other states. Medicaid State Plan revisions will need to be considered as part of the coordinated realignment of funding activities discussed above. Changes in state funding buckets must support the optimized use of Medicaid's Rehabilitation Option and Home and Community Based Waivers.

This effort is related to the ultimate finance strategy intent of ensuring that defined entitled services correspond with best practice and emerging best practice.

# 7. Regulatory, rule and/or practice modifications

**Objective:** Reduce unnecessary regulations, rules, monitoring and attendant administrative costs in order to support system reform goals and increase funds available for services and supports.

All current (and any new) regulations, rules and/or practices are being evaluated to determine if they fit and if they are applicable to reform efforts.

It should also be noted that systems might need to identify and request state modifications/ elimination of existing regulations, rules and/or practices that promote inefficiencies. Systems should identify these and forward them to the Division for follow-through. The Division has set a goal of reducing by 50% current rules and regulations.

This effort is related to the ultimate finance strategy intent of: (a) expectations of regulations, rules and/or practices to promote systems efficiency in public accountability; (b) clearly identifying and justifying indirect costs of regulatory practices; and (c) increasing the availability of funds for direct supports, services, treatment and care.

# 8. CAP-MR/DD Waiver redesign and development

**Objective:** To increase federal funds supporting services for individuals with developmental disabilities already being served in the system and creating state and county savings to be redirected to system reform goals.

The CAP-MR/DD Waiver is currently being re-written. The particular emphasis of the redesign is threefold: (a) developing service bands that reflect severity of need; (b) compatibility with the development of person-centered plan oriented and consumer controlled support budgets and (c) ultimate relative fit with the new CMS Independence Waiver (for future transition).

There are a number of individuals currently being served who qualify for CAP MR/DD services and who may be receiving some state Medicaid plan services with the remainder of the cost of services being subsidized by state funds. Individuals residing in DDA homes are examples. In order to ensure the best response to the needs of these individuals and optimize full legitimate federal participation, a number of these individuals should be enrolled in the CAP MR/DD program. Furthermore, as a result of any state funds that become available as a result of these enrollment efforts (net savings after the application of federal revenues), individuals on the waiting list for CAP MR/DD services should also be enrolled (with the net savings applied as the match requirements).

This effort is related to the immediate budget crisis by securing legitimate federal Medicaid match funds for people who could be served by the CAP MR/DD program who are potentially supported, in part, by state dollars only. This effort is related to the ultimate finance strategy, as it is intended to optimize legitimate federal participation as a revenue source.

This effort is also related to the ultimate finance strategy intent of ensuring that defined entitled optional services correspond with best practice and emerging best practice, particularly as related to consumer control and responsibility in purchase of supports and services.

# 9. Integrated Payment and Reporting System (IPRS) Roll Out

**Objective:** To implement a successful roll out of the IPRS system, as evidenced by cash flow of 95 percent of *clean* claims within a 30-day turnaround for area programs.

The IPRS system is intended to provide LMEs with a data and claims payment infrastructure that aligns reporting and payment with state-intended financing and policy, including targeted populations and services, supports, treatment and care. It is also a platform for claims processing that can apply to the overall future strategy. SFY 02-03 offers a *test year* to best ensure systems performance for future years.

This effort will provide person-specific financially related support for serving people identified as the most critical.

#### 10. Medicaid eligibility

**Objective**: To optimize federal dollars through targeted changes in eligibility, increased eligible identification, redirecting state/county maintenance of effort toward community based services reflecting system reform goals.

In comparison to national averages, the number of enrolled Medicaid beneficiaries with disabilities in North Carolina is low. The current system denies North Carolina its full share of federal financial

participation by leaving people who are not potentially eligible, un-enrolled and by not covering all of the community-based services essential to avoiding over-utilization of institutional care and increasingly non-Medicaid reimbursable care. There has not been an aggressive effort to secure Medicaid enrollment of people we support and serve. This is one of the critical functions of care coordination and case management — assuring that an individual secures all of the benefits and resources they are entitled. Additionally, failure to secure Medicaid benefits will simply find unnecessary state and local subsidization of support, services, treatment and care, particularly using state funds.

Although we may not increase overall state and county share of Medicaid funding liability, we must grow components of the Medicaid budget when they legitimately support system reform and can be at least partially offset by savings in institutional and trans-institutional care. This is known as *optimizing Medicaid*. There are two ways to do this. First, the Medicaid State Plan and Home and Community Based Waiver revisions must reflect less restrictive approaches to Medicaid eligibility for individuals in the target populations. Second, the services eligible for federal reimbursement must support system reform objectives of consumer-driven; recovery, outcomes and performance-oriented and community based services. In order to achieve this end, state funds, including institutional dollars and county maintenance of effort, financing not being used as Medicaid match should be re-directed to support costs associated with Medicaid enrollments of people currently supported and served. This process would also be extended to an increase in Medicaid beneficiaries resulting from a more aggressive enrollment of people entering the system.

This effort is related to the immediate budget crisis by securing legitimate federal Medicaid match funds for people currently and in the future who are supported by state only dollars. This effort is related to the ultimate finance strategy in that it is intended to optimize legitimate federal participation as a revenue source. Additionally, state funds that become available resulting from federal revenues replacing 100 percent state support would be re-directed to support persons in the target/priority population who are not Medicaid eligible.

#### 11. Coordination of benefits

**Objective:** To develop the infrastructure and reporting capabilities to ensure local programs can capture and track  $3^{rd}$  party billings.

An emphasis will be placed on securing and appropriately applying all first and third private party revenues. This includes implications, as applicable, of the obligations of providers to accept an insurer's payment as payment in full and of applying collections against the net reimbursement sought from public finance sources.

This effort is related to the immediate budget crisis in that it ensures that private reimbursements are fully captured and applied to mitigate public subsidization. This effort is related to the ultimate finance strategy in that it is intended to optimize all legitimate private funding resources as revenue

sources. Public funds that become available as a result of this process would be re-directed to provide direct funding for needed supports, services, treatment and care.

# 12. Community Placement

**Objective:** To successfully transition institutionalized individuals to their home communities, per the Olmstead plan, with an associated movement of institutional dollars to the community to support these individuals.

The State of North Carolina has a large number of individuals with mental illness and individuals with developmental disabilities residing in state-operated facilities. Along with the public policy concerns about the need for people to be a part of their natural communities, the funds associated with these institutional arrangements are resources that are in high, fixed-cost programs.

As part of Olmstead planning, and in conjunction with the bridge funds provided in the Mental Health Fund Trust (MHFT), area programs have been responsible for developing community placement plans. In order to move these along efficiently, each area program needs to make these plans final and implement them. It should be noted that area programs should be moving toward using private systems to provide these supports, services, treatment and care. Medicaid State Plan changes and Home and Community Based Waiver redesign must support these efforts.

In completing this process, each area program will negotiate a state net funding amount to be transferred from state institutions to the area program budget. This would include start-up financing (which could include MHTF dollars) and SFY 02-03 phase-in and SFY 03-04 full year state net costs necessary for area program and state-operated program planning. Revenue-side planning will include all resources to be used to support expenditure plans. Medicaid match requirements will be satisfied through application of the net state funds transferred and county maintenance of effort funds that are not being used as Medicaid match. In the event that there are no county funds available, the state net match can be used as the full required match obligation, where sufficient.

The net state financing transfer cannot be dollar for dollar, since it often costs more per bed day to operate facilities with lower occupancy rates. The actual amount of this differential, however, will be smaller as the facilities begin to achieve larger reductions in capacity. However, if all area programs move forward in making their plans final, the negotiation process will be able to take into account the cumulative effect of all area program plans. That is, more rapid downsizing can occur through such things as closure of units, rather than simply leaving a few beds empty on units otherwise being operated. As appropriate, the more people who are able to move into the community, the greater the available proportion of transfer. At the same time, if the Medicaid strategy optimizes federal financial participation (FFP) for community services, some of the transfer differential can be offset by increased availability of FFP for community services.

This process includes the ability to move funds into the community that exceed the needs of the people actually moving (with an understanding that once bed days are reduced to an agreed upon

level, any use over that level would be at the LME'sexpense). Reimbursements are included in planning revenue in addition to the net state funds involved in the transfer. It is not uncommon, particularly with psychiatric hospitals, that given the nature of financing state-operated systems (intensity of state funds), the state funds involved in the transfer are sufficient to meet unmet needs, community demand and to build community capacity necessary to provide alternatives to state inpatient services. This is especially true when the Medicaid strategy is designed to optimize the use of FFP.

Planning for people with developmental disabilities will include use of CAP-MR/DD slots as preferred over new ICF-MR development. This includes community *move through* efforts such as current ICF-MR residents' transfer to CAP-MR/DD supported arrangements and community placements into existing ICF-MR beds.

This effort is related to the immediate budget crisis in that it ensures that state funds are moved to support people currently residing in state operated institutions with any funding benefits being applied to expanded community capacity (mechanisms to prevent institutionalization of current and future community clients, applied to prevent reductions in support, services, treatment and care, as examples). This effort is related to the ultimate finance strategy in that it is intended to optimize the manner in which (and to whom) the community and the state provides supports, services, treatment and care. In addition, this further aligns public financing on the community side.

# 13. Community outreach and alternatives

**Objective:** To identify mental retardation center outreach services currently being provided and initiate planning for transfer of these services into the private provider network in the LME geographic area, with associated transition of institution funds to the communities to support this core service function.

This area is related differently to people with developmental disabilities and individuals with mental illness.

State mental retardation centers currently provide a substitute for community capacity. The out-reach programs provide services, treatment and care to individuals with developmental disabilities residing in communities. Some of these efforts may be redundant because of existing resources in communities and may or may not be coordinated with the full array of community supports, services, treatment and care.

In order to best develop community capacity, each area program should identify MR center outreach services currently being provided and initiate planning for transfer of these services into their private provider network. Planning would include fiscal negotiations with the state similar to those regarding community placement efforts.

State psychiatric hospitals currently provide an array of acute care and crisis services. These are capacities that should exists as part of a community's provider network (community inpatient, crisis stabilization [crisis residential and/or outreach], as examples).

In order to best develop community capacity, each area program should identify their use of state psychiatric hospital acute and crisis services and initiate planning for transfer of these services into their private provider network. Planning would include fiscal negotiations with the state similar to those regarding community placement efforts.

This effort is related to the immediate budget crisis. It ensures that state funds currently used by communities for state-operated institution services could be applied to community capacity-building efforts to keep services, these people and others like them, closer to home. This effort is related to the ultimate finance strategy in that it is intended to optimize the manner and to whom the community and the state provide supports, services, treatment and care. In addition, this further aligns public financing on the community side.

# 14. Target/Priority Population

**Objective:** To establish target populations, a defined service array and the ability to track data to demonstrate shifts in services received consistent with system reform goals.

The establishment of target/priority populations is intended to prevent adverse selection and to ensure that people in greatest need and at greatest risk are served. This will require LMEs to work quickly and closely with their communities and provider systems (including the area program as a provider, where applicable) in order to develop transitions and resources for non-target/priority populations. This also requires LMEs to have competent and efficient access management capacities. The sooner this is initiated, the sooner systems will be able to minimize support, service, treatment and care financing reductions for the target/priority population, including the need to identify and respond to target/priority population individuals not currently served. The Medicaid finance strategy must ensure that target populations can be eligible and community-based services sufficient to prevent unnecessary institutionalization can be financed using federal funds.

This effort is related to the immediate budget crisis by ensuring that reductions in supports, services, treatment and care are not first targeted toward individuals the system should be serving. This effort is related to the ultimate finance strategy in that it is intended to prevent adverse selection.

# 15. Innovations in practice

**Objective:** To establish state direction for the first three key priorities for best practice implementation at the local level.

This objective speaks to support, service, treatment and care practices and administration and management practices. Collaboration efforts among systems with shared responsibilities for individuals and populations and coordination among other systems responsible for providing

general supports, services, treatment and care should also be considered in this effort. Collaboration assures that the local public specialty system is responding to people whose needs are best addressed among systems. *Responding* includes efforts of participation (systems of care, as an example). Coordination is intended to include making sure that responsible systems are in fact responding to shared individuals (school services, as an example).

Best practice and emerging best practices must be identified and implemented among systems to ensure that exemplary outcome oriented models are applied to the people we serve. This will require LMEs to work quickly and closely with their provider systems (including the area program as a current provider, where applicable) in order to develop transitions to innovations in practice. The sooner this is initiated, the sooner systems will be able to ensure that reductions are directed at outdated and inefficient models of practice, while funding is directed at practice innovations.

Systems should identify and request state modifications/elimination of existing regulations, rules and/or practices that promote inefficiencies. Systems should identify these and forward them to the Division for follow-through.

This effort is related to the immediate budget crisis by ensuring that innovations in practice are first applied in an effort to minimize reductions in supports, services, treatment and care, and to ensure that administrative and management efficiencies are pursued to create indirect savings that could be earmarked for funding reductions. This effort is related to the ultimate finance strategy intent of: (a) expectations of exemplary LME and provider systems performance; (b) clearly identifying and justifying indirect costs of public local management and administration and management costs of provider systems and (c) increasing the availability of funds for direct supports, services, treatment and care, particularly those related to best practice and emerging best practice models.

# 16. Expedited LME development

**Objective:** To identify location(s) to implement full LME functions in SFY 03-04, including flexible funding.

As is evident in much of this section, there is a natural incentive to expedite the efforts of developing an LME. The current budget crisis clearly requires greater administrative and management efficiencies. Along with organizing strategies to respond to the items described in this section that best promote the development of the LME (developing innovations in practice through the provider system while diminishing outdated and inefficient models of practice the area program currently operates, as an example), other actions including moving forward with consolidations are also necessary. Development of the local business plan within the constraints of the area program will not suffice — the LME is a new and different entity. Given the need to plan with regard to the budget crisis, there would be greater utility in developing the LME as a component of the budget crisis response plan.

This effort is related to the immediate budget crisis by providing an opportunity to design the emerging LME (and dealing with issues of transition) in conjunction with development of a response to the budget crisis (thus, an immediate and future oriented response). This effort is related to the ultimate finance strategy intent of: (a) expectations of exemplary LME systems performance; (b) clearly identifying and justifying indirect costs of public local management and (c) increasing the availability of funds for direct supports, services, treatment and care.

# SUMMARY: BUILDING THE FUTURE ENVISIONED IN SYSTEM REFORM

# SFY 02/03: Foundation building

As is evident, SFY 02-03 provides the state and local, public and private systems an opportunity to demonstrate competencies required in the evolving State Plan. As difficult as it is, the current state budget crisis provides a live and real time challenge for systems to demonstrate how they can manage most efficiently and creatively. Given that future budget growth will most likely be slow and limited at best, courageous leadership and competent management will be a mainstay in the evolving system. This also provides exemplary systems — in this state and across the country — currently not involved in North Carolina to consider options to enter these efforts and compete and/ or replace systems that will exit or not adequately respond to unmet challenges.

During SFY 02-03 the state will develop products that more clearly define the expectations and parameters of the evolving system. Furthermore, efforts by the systems during this difficult budget year and initial full reform planning year will allow for an evaluation of who is ready and who is not.

#### SFY 03/04: Pilot innovations and systems development

During SFY 02/03, the emerging LMEs will be completing their local business plans for submission in January and April 2003. Emerging LMEs in the first phase will be provided opportunities to negotiate pilot components of LME functions. These pilot components will provide opportunities to move practice beyond the essential parameters of the LME as described in the State Plan.

It has been acknowledged that the State Plan LME model has *practical* and *political margins*. *Practical margins* are built in as legitimate precautions regarding competencies to fully and comprehensively perform core functions. *Political margins* are built in to satisfy real and/or perceived concerns of systems stakeholders. Sometimes it is difficult to distinguish the difference between these two types of margins. However, with every margin, there is a cost. It is expected that there will be some controlled pilots that will have minimal margins built into the LME model. There is a need to test the full and comprehensive LME model for future dissemination.

In terms of financing, there will be efforts to begin to blend funding sources. The state currently operates in a *funding silo matrix*. That is, funding services/supports to disability groups by categorized funding streams. This creates a type of split that limits ability to plan globally, as the system is restricted to planning within small funding *buckets*. Ultimately, there is a need to optimize these funding streams through a process of blending them as much as possible.

During SFY 02-03, and particularly regarding the first phase of emerging LMEs, state statutory and regulatory changes will be carefully explored in an effort to eliminate silos. In addition, federal regulations will also be carefully examined and waivers may be pursued in order to pilot innovations in financing. Furthermore, an incentive/disincentive-financing scheme related to the use of state-operated services would be carefully explored, including a pilot with some of the first phase of emerging LMEs. Systems practices regarding past use of state-operated services will be considered in order to ensure that positive past practices and continuing these practices are sufficiently rewarded. This reward system will be applied in a manner to make sure that consumers are not punished for poor systems performance.

## SFY 04/05 through 06-07: Model advancements

With proper evaluation of pilot innovations, knowledge of what was learned will become available during SFY 03-04. There will be wider application SFY 04-05 through 06-07. This will ultimately require substantial changes to the State Medicaid Plan (and waivers) and state financing statutes and regulations necessary for statewide application. Additionally, throughout SFY 02-03 through 06-07, we will be examining developments in other states to explore additional knowledge for potential application to North Carolina.

# STATE STRATEGIC BUSINESS PLAN

The State Plan implementation document and the state business plan timeline, included in the first version of the State Plan, have been largely re-worked and combined together into the state strategic business plan. Strategic planning and execution at the state level encompasses a wide array of activities necessary in the transition from old to new. *State Plan 2002: Blueprint for Change* is the state's business plan for reforming the state mh/dd/sas system. The new strategic plan outlines responsibilities and tasks of the Division of MH/DD/SAS required to implement reform and a timeline for their completion. The strategic plan incorporates the mission and principles of the State Plan in both its process and outcome, and is designed to compliment and support creation of local business plans.

As the Division moves forward in its reorganization, implementation structure of committees and workgroups and timeframes for completing work products may change. Supplemental bulletins that report on these changes will be issued, included in the quarterly reports to the LOC and posted on the Department web site.